IHSS Provider Reimbursement Webinar

California Department of Social Services
Adult Programs Division

November, 2017

Introduction

- Purpose
- Acronyms Used
- Background
- County's role in determining if a Share of Cost is correct
- Completion of the GEN 1384
- Submission of the GEN 1384
- California Department of Social Services' role in processing the reimbursement claims
- Resources and References

Purpose

- Increase awareness of the Provider Reimbursement Process
- Provide training to counties on their role
- Share information about processing timeframes
- Clarify role of the California Department of Social Services

Acronyms Used in this Presentation

- CDSS – California Department of Social Services
- SOC – Share of Cost
- CMIPS II – Case Management, Information, and Payroll System
- SCO – State Controller's Office
- MEDS – Medi-Cal Eligibility Data System

Background

- Recipients may be required to pay a Medi-Cal SOC to receive benefits.
- CMIPS II interfaces with MEDS to determine SOC.
- If outstanding SOC exists, that amount is withheld from provider's warrant.
- If MEDS displays a SOC, a deduction from provider's warrant will occur.
- If an erroneous deduction occurs, CDSS can reimburse the provider directly.

What is Provider Reimbursement?

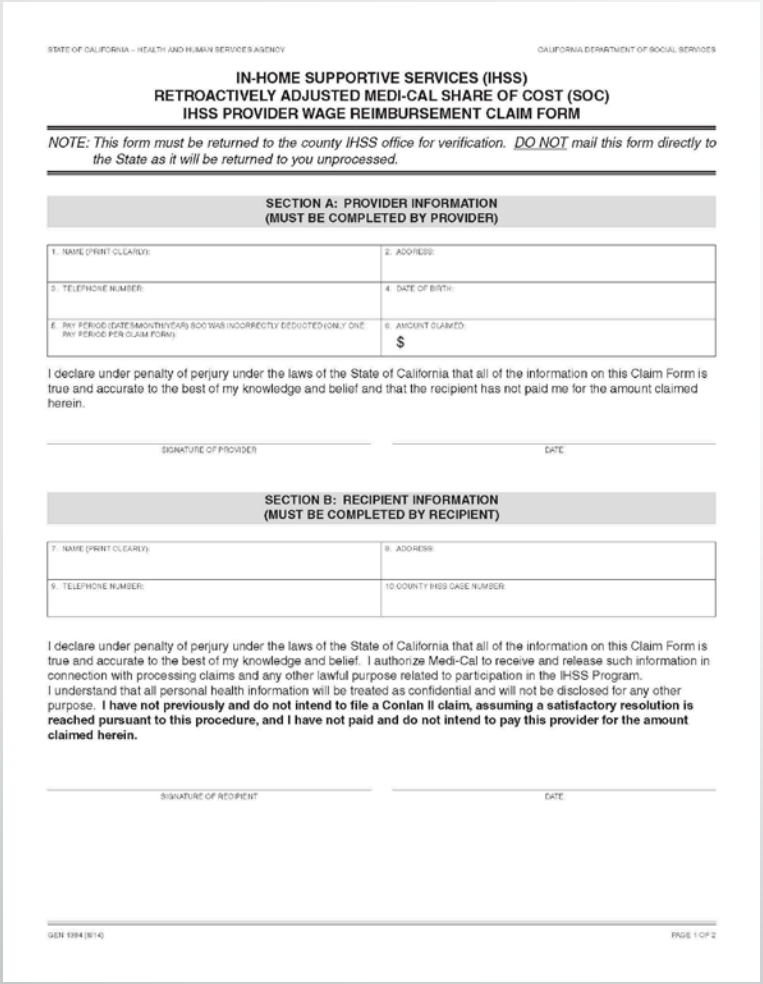
- Available for SOC deductions occurring on or after July 1, 2014.
- Recipient or provider contacts county regarding incorrect SOC deduction.
- County determines if SOC deduction is incorrect.

County's Role

Provider Reimbursement Process

- Provider/recipient notifies County of potentially erroneous SOC withholding.
- County determines if a SOC withholding is erroneous.
- County provides provider/recipient with page 1 of GEN 1384 to complete and sign.
- County completes page 2 of GEN 1384 and submits via email to CDSS.

GEN 1384



STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS)
RETROACTIVELY ADJUSTED MEDI-CAL SHARE OF COST (SOC)
IHSS PROVIDER WAGE REIMBURSEMENT CLAIM FORM

NOTE: This form must be returned to the county IHSS office for verification. DO NOT mail this form directly to the State as it will be returned to you unprocessed.

SECTION A: PROVIDER INFORMATION
(MUST BE COMPLETED BY PROVIDER)

1. NAME (PRINT CLEARLY):	2. ADDRESS:
3. TELEPHONE NUMBER:	4. DATE OF BIRTH:
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

SIGNATURE OF PROVIDER — DATE

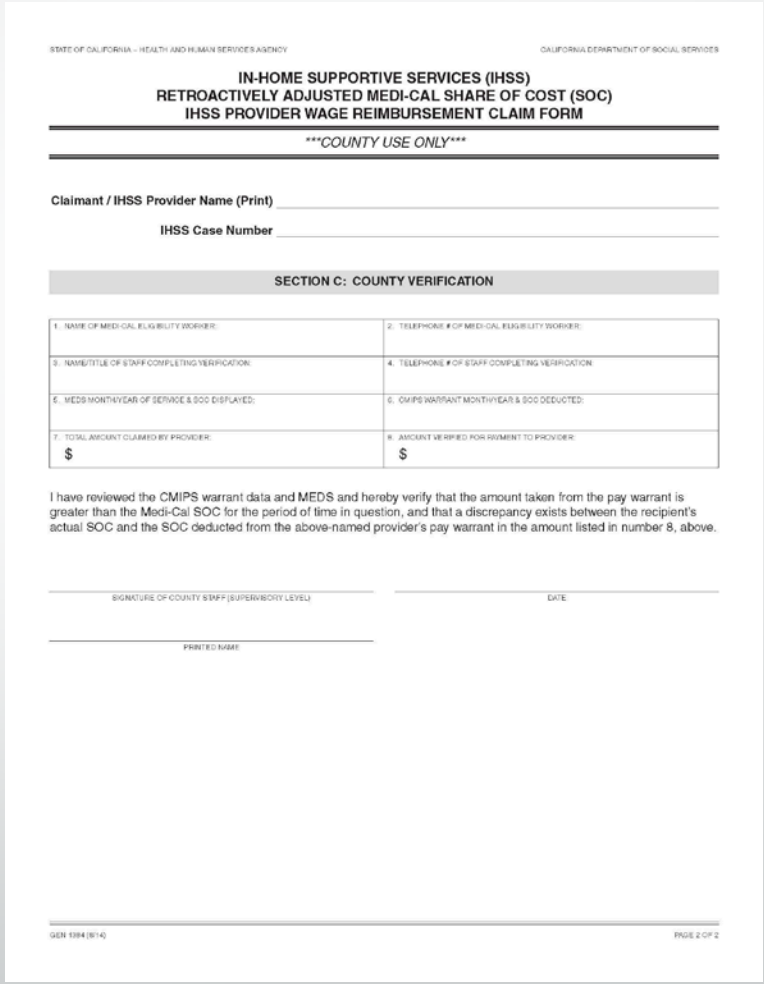
SECTION B: RECIPIENT INFORMATION
(MUST BE COMPLETED BY RECIPIENT)

7. NAME (PRINT CLEARLY):	8. ADDRESS:
9. TELEPHONE NUMBER:	10. COUNTY IHSS CASE NUMBER:

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief. I authorize Medi-Cal to receive and release such information in connection with processing claims and any other lawful purpose related to participation in the IHSS Program. I understand that all personal health information will be treated as confidential and will not be disclosed for any other purpose. **I have not previously and do not intend to file a Conlan II claim, assuming a satisfactory resolution is reached pursuant to this procedure, and I have not paid and do not intend to pay this provider for the amount claimed herein.**

SIGNATURE OF RECIPIENT — DATE

GEN 1384 (8/14) — PAGE 1 OF 2



STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS)
RETROACTIVELY ADJUSTED MEDI-CAL SHARE OF COST (SOC)
IHSS PROVIDER WAGE REIMBURSEMENT CLAIM FORM

****COUNTY USE ONLY****

Claimant / IHSS Provider Name (Print) _____

IHSS Case Number _____

SECTION C: COUNTY VERIFICATION

1. NAME OF MEDI-CAL ELIGIBILITY WORKER:	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER:
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION:	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION:
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED:	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL) — DATE

PRINTED NAME

GEN 1384 (8/14) — PAGE 2 OF 2

Process – SOC Deduction

Correct SOC Deduction

- Notify requestor that the amount deducted was correct.
- If disputed the requestor is directed to contact the Medi-Cal eligibility worker.

Incorrect SOC deduction

- Obtain GEN 1384 from CDSS.
- Give page 1 (section A&B) of GEN 1384 to requestor.
- Verify correct completion of page 1.
- Complete page 2.
- Send Completed GEN 1384 to CDSS.
- Notify requestor that claim has been forwarded to CDSS.

GEN 1384 – Verify Completion of Page 1 Section A: Provider Information

SECTION A: PROVIDER INFORMATION
(MUST BE COMPLETED BY PROVIDER)

1. NAME (PRINT CLEARLY): Last, First	2. ADDRESS:
3. TELEPHONE NUMBER:	4. DATE OF BIRTH:
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

SIGNATURE OF PROVIDER

DATE

GEN 1384 – Verify Completion of Page 1 Section A: Provider Information

SECTION A: PROVIDER INFORMATION
(MUST BE COMPLETED BY PROVIDER)

1. NAME (PRINT CLEARLY): Last, First	2. ADDRESS: 12 Main St. #A, Anytown, CA 9xxxx
3. TELEPHONE NUMBER:	4. DATE OF BIRTH:
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

SIGNATURE OF PROVIDER

DATE

GEN 1384 – Verify Completion of Page 1 Section A: Provider Information

SECTION A: PROVIDER INFORMATION
(MUST BE COMPLETED BY PROVIDER)

1. NAME (PRINT CLEARLY): Last, First	2. ADDRESS: 12 Main St. #A, Anytown, CA 9xxxx
3. TELEPHONE NUMBER: (999) 555-1212	4. DATE OF BIRTH:
5. PAY PERIOD (DATES/MONTH/YEAR) SDC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

SIGNATURE OF PROVIDER

DATE

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SECTION A: PROVIDER INFORMATION
(MUST BE COMPLETED BY PROVIDER)

1. NAME (PRINT CLEARLY): Last, First	2. ADDRESS: 12 Main St. #A, Anytown, CA 9xxxx
3. TELEPHONE NUMBER: (999) 555-1212	4. DATE OF BIRTH: mm/dd/yyyy
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

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1. NAME (PRINT CLEARLY): Last, First	2. ADDRESS: 12 Main St. #A, Anytown, CA 9xxxx
3. TELEPHONE NUMBER: (999) 555-1212	4. DATE OF BIRTH: mm/dd/yyyy
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM): 3/16/2017	6. AMOUNT CLAIMED: $

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

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3. TELEPHONE NUMBER: (999) 555-1212	4. DATE OF BIRTH: mm/dd/yyyy
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM): 3/16/2017	6. AMOUNT CLAIMED: $ 300

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

SIGNATURE OF PROVIDER

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5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM): 3/16/2017	6. AMOUNT CLAIMED: $ 300

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SIGNATURE OF PROVIDER

DATE

GEN 1384 – Verify Completion of Page 1 Section B: Recipient Information

SECTION B: RECIPIENT INFORMATION
(MUST BE COMPLETED BY RECIPIENT)

7. NAME (PRINT CLEARLY): Last, First	8. ADDRESS:
9. TELEPHONE NUMBER:	10. COUNTY IHSS CASE NUMBER:

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief. I authorize Medi-Cal to receive and release such information in connection with processing claims and any other lawful purpose related to participation in the IHSS Program.
I understand that all personal health information will be treated as confidential and will not be disclosed for any other purpose. **I have not previously and do not intend to file a Conlan II claim, assuming a satisfactory resolution is reached pursuant to this procedure, and I have not paid and do not intend to pay this provider for the amount claimed herein.**

SIGNATURE OF RECIPIENT

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SECTION B: RECIPIENT INFORMATION
(MUST BE COMPLETED BY RECIPIENT)

7. NAME (PRINT CLEARLY):	8. ADDRESS:
Last, First	12 Main St. #A, Anytown, CA 9xxxx
9. TELEPHONE NUMBER: (999) 555-1213	10. COUNTY IHSS CASE NUMBER:

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief. I authorize Medi-Cal to receive and release such information in connection with processing claims and any other lawful purpose related to participation in the IHSS Program.
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Last, First	12 Main St. #A, Anytown, CA 9xxxx
9. TELEPHONE NUMBER:	10. COUNTY IHSS CASE NUMBER:
(999) 555-1213	9999999

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Last, First	12 Main St. #A, Anytown, CA 9xxxx
9. TELEPHONE NUMBER:	10. COUNTY IHSS CASE NUMBER:
(999) 555-1213	9999999

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SIGNATURE OF RECIPIENT

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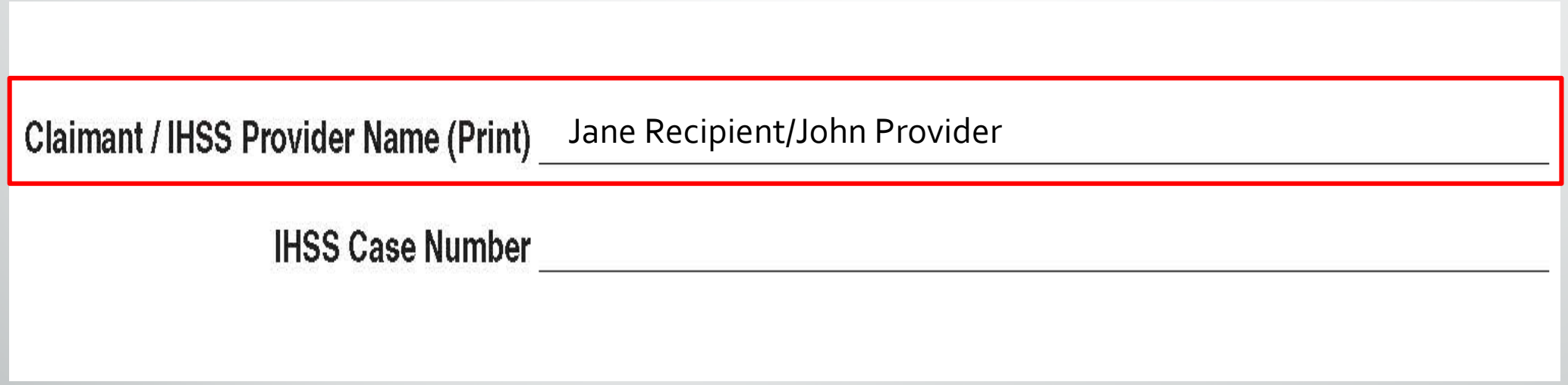

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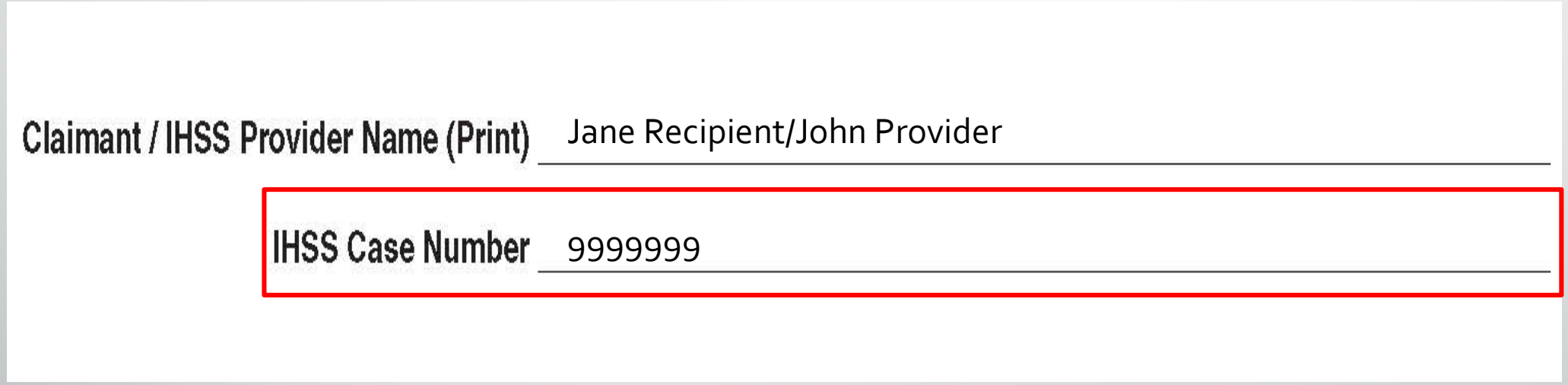

GEN 1384 – Complete Page 2
Section C: County Verification

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1. NAME OF MEDI-CAL ELIGIBILITY WORKER: Last, First	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER:
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION:	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION:
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED:	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL) _____ DATE _____

PRINTED NAME _____

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1. NAME OF MEDI-CAL ELIGIBILITY WORKER: Eligibility Worker: Last, First	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER: (999) 555-1214
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION:	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION:
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED:	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
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3. NAME/TITLE OF STAFF COMPLETING VERIFICATION: IHSS Case Worker: Last, First	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION: (999) 555-1215
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED:	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

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3. NAME/TITLE OF STAFF COMPLETING VERIFICATION: IHSS Case Worker: Last, First	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION: (999) 555-1215
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED: 3/2017 $240	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

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3. NAME/TITLE OF STAFF COMPLETING VERIFICATION: IHSS Case Worker: Last, First	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION: (999) 555-1215
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED: 3/2017 $240	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED: 3/2017 $500
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL) _____ DATE _____

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1. NAME OF MEDI-CAL ELIGIBILITY WORKER: Eligibility Worker: Last, First	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER: (999) 555-1214
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION: IHSS Case Worker: Last, First	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION: (999) 555-1215
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED: 3/2017 $240	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED: 3/2017 $500
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $ $300	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL) _____ DATE

PRINTED NAME

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1. NAME OF MEDI-CAL ELIGIBILITY WORKER: Eligibility Worker: Last, First	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER: (999) 555-1214
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION: IHSS Case Worker: Last, First	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION: (999) 555-1215
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED: 3/2017 $240	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED: 3/2017 $500
7. TOTAL AMOUNT CLAIMED BY PROVIDER: $ $300	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $ 260

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

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7. TOTAL AMOUNT CLAIMED BY PROVIDER: $ $300	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: $ 260

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SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL) _____ DATE _____

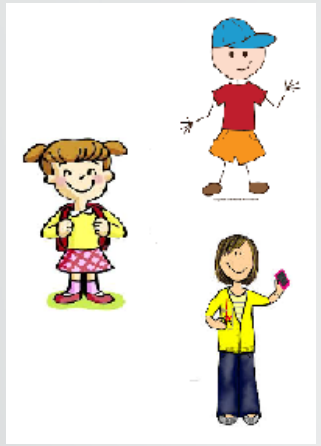
PRINTED NAME _____

Send Completed GEN 1384 to CDSS

So what should be submitted by the County?

- Email completed GEN 1384 to providerreimbursement@dss.ca.gov within 10-days of receipt from provider/recipient.
- Submit GEN 1384 from work email address
  - Do not scan directly to CDSS.
- Submission materials
  - Completed GEN 1384.
    - Scanned to pdf. Please do not send gif, jpegs, word, or other formats.
    - One recipient/provider relationship per pdf.
    - Multiple pdfs per email are acceptable.
    - Do not submit MEDS printouts, CMIPS II printouts, FAX coversheets, or other documents.
    - If CDSS requires additional information, a CDSS analyst will contact you.

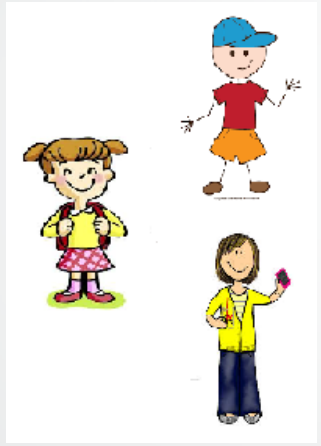
One recipient, one provider – one pdf containing the GEN 1384s, with multiple GEN 1384s for separate service periods allowed per pdf.



On recipient, multiple providers – one pdf containing the GEN 1384s per provider, multiple GEN 1384s for separate service periods allowed per pdf.

One provider, multiple recipients – one pdf containing the GEN 1384s per recipient, multiple GEN 1384s for separate service periods allowed per pdf.

All in one email, if desired



CDSS' Role

CDSS Process

So what happens with the claim once it is received by CDSS?

- Send provider Acknowledgement Letter of receipt of claim.
- Claims are processed in the order received.
- CDSS has 60-days from receipt to process.
- Upon adjudication CDSS sends decision letter to recipient, provider, and county requestor.
- Warrant is processed by SCO.
- Provider receives warrant within 30-days of claim approval by CDSS.

Questions?

- For questions pertaining to the Provider Reimbursement Program, please call 877-508-1327 or email providerreimbursement@dss.ca.gov.

References

- ACL 14-40 - IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER WAGE REIMBURSEMENT FOR UNPAID EXCESS MEDI-CAL SHARE OF COST DEDUCTIONS